REVIEW OF THE MEDICARE PARTIAL HOSPITALIZATION BENEFIT

Heath Care Financing Administration
Office of Strategic Planning

February 2000

HCFA Working Paper
OSP-00-01

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Executive Summary

OBRA 87 expanded Medicare's mental health benefit to include partial hospitalization (PH) program services furnished by a hospital. OBRA 90 expanded the eligible providers of this service to include Community Mental Health Centers (CMHCs). With declining inpatient lengths of stay, particularly in PPS exempt psychiatric hospitals and units, and the provider expansion to CMHCs, PH costs and utilization soared during the mid-1990s. About 88,000 beneficiaries were treated in PH programs in 1997, with CMHC programs treating about 40% of these.

PH program costs (payments to providers) were $550 million in 1997, more than twice the level experienced in 1995, $245 million. Hospital PH program costs doubled from $100 million in 1995 to $200 million in 1997, while CMHC PH program costs more than doubled in the same time period, from $ 145 million to $ 350 million. The 1997 CMHC average cost per patient of $10,266, was more than twice the average hospital PH program cost, $3,755. Part of the reason for this cost differential is that CMHC PH programs experienced a decline in the number of patients treated, while hospital PH programs experienced an increase.

In 1998, an Office of Inspector General (OIG) audit found that 91 % of the partial hospital (PH) units of service provided by a sample of CMHCs in FY 1997 were billed in error. Based on the medical necessity criteria employed by each Fiscal Intermediary, the OIG found that: 1) 79% of the units of service were not considered to be PH services, and 2) about 60% of the sampled beneficiaries did not meet the criteria to be eligible for PH services.[1]

[1] Computed from data shown in the October 1998 OIG Report.

A subsequent informal review of the medical records used in the OIG audit was made by HCFA's Program Integrity Group. They found that three service modalities appear to be delivered under the present PH rubric: 1) acute partial hospitalization, 2) less intensive outpatient programs, and 3) psycho-social rehabilitation. Acute partial hospitalization emphasizes a medical model of care, in which PH is a substitute for or an immediate step-down modality from inpatient care, while the other two modalities do not serve as substitutes for inpatient care. The present statutory language specifies that a physician must certify that a beneficiary admitted to a partial hospital program would otherwise require inpatient care.[2]

The OIG audit finding prompted several questions, including:

1. Should CMHCs continue to provide this benefit?

2. How should inappropriate utilization be controlled?

3. How should the benefit be restructured and defined?

The focus of this paper is the second and third concerns, inappropriate utilization and benefit restructuring of the PH benefit, which were discussed as part of the 10 point action plan announced by the Health Care Financing Administration (HCFA) in September 1998. An intra-agency HCFA Task Group was formed to research the issue and report findings to the HCFA Administrator. Based on the analyses and information contained in this report, the HCFA Task Group concluded the following:

1. A significant portion of care provided under Medicare's PH benefit does not appear to be a substitute for acute hospital care as evidenced by the

[2] Section 1835(a)(2)(F) of the Social Security Act

large proportion of episodes exceeding 90 days.

An analysis of PH claims data for three years, 1995 through 1997, supports the notion that a significant portion of beneficiaries were receiving supportive services, such as psycho-social rehabilitation and day care, which are not covered services under Medicare. This conclusion assumes that an intensive level of care, which is intended to be a substitute for acute inpatient hospitalization, would not last beyond 60 to 90 days. Stays in excess of these thresholds can be attributed to longer term care modalities, i.e., psycho-social rehabilitation and less intense outpatient services. Using a proxy measure to define the duration of an episode, in 1996 almost 60% of the stays exceeded 60 days in CMHC PH programs (47% over 90 days), while about 30% exceeded 60 days in hospital PH programs (23% over 90 days).

2. Partial hospitalization is considered to be an acute care service by the non-Medicare purchasers of mental health services surveyed for this report.

Most of the organizations surveyed use managed care techniques to control and coordinate PH services; consequently, they did not encounter the abuses experienced by Medicare, which does not use managed care approaches in its traditional fee for service program.

3. Improved oversight of this benefit as envisioned in the Administrator's 10 point plan is consistent with the practices of other purchasers of partial hospitalization services. Such strategies include:

- Using standardized definitions and protocols in the medical review of providers.
- Intensifying reviews.
- Defining more stringent criteria for delivering the service.

Consistent with these practices, HCFA has issued a Program Instruction for Fiscal Intermediaries, which is included in Appendix 1.

4. The statutory language authorizing partial hospitalization may have caused confusion about the intent of the benefit being an intensive, active treatment.

Some of the confusion over the application of Medicare's PH benefit may be due to the statutory language that describes the benefit; consequently, there have been varying interpretations of what constitutes partial hospitalization.

Organization of this Report

To provide a framework to better understand the PH benefit and the report findings, additional background information is provided in the remainder of the report: Section 1, "The Medicare Mental Health Benefit;" Section 2, "The Partial Hospital Benefit;" Section 3, "PH Utilization Measures and Payment Trends;" Section 4, "Non-Medicare Use of Partial Hospitalization," and Section 5, "Conclusion."

Section 1: Medicare Mental Health Coverage

There are two basic types of Medicare mental health providers: **facilities** and **professionals**. Facilities furnish a therapeutic environment and non-billable professional care. Hospitals, nursing homes, and CMHCs are examples of facility providers. Professional practitioners are licensed by a state and have authority to separately bill for services. Physicians, psychiatrists, licensed clinical social workers, and clinical psychologists are recognized professionals for Medicare Part B billing purposes. While registered nurses (RNs) are professionally licensed, they generally cannot bill for their professional services unless they are nurse practitioners (NPs) or certified nurse specialists (CNSs).

Medicare provides almost unlimited acute inpatient psychiatric care benefits, except for the spell of illness day limits that apply to all inpatient care and the 190 lifetime day limit that applies to PPS exempted specialty psychiatric hospitals.[3] Outpatient facility services of partial hospitalization (furnished in hospitals and CMHCs) and hospital outpatient clinic visits are unlimited and carry the same co-pays as inpatient professional mental health services (20%). Billable professional services furnished by physicians, psychiatrists, and clinical psychologists can be furnished in any care setting. Licensed clinical social workers cannot independently bill for inpatient or outpatient services, since their salaries are considered part of the facility reimbursable cost. However, they may bill for professional services in outpatient care settings outside of a facility, such as in their own practice, or under the direction of a physician through the "incident to" billing protocols. The Balanced Budget Act of 1997 allowed clinical nurse specialists, nurse practitioners, and physician assistants to independently bill in either inpatient or outpatient settings. However, **outpatient professional service** co-pays are higher as a result of the “outpatient mental health limitation,” in which the Medicare payment is reduced to 62.5% of the fee schedule. This limitation does not apply to **facility delivered services**, such as outpatient hospital, PH, or professional services for medical

[3] The 190 lifetime limit does not apply to psychiatric care furnished in general hospitals.

management, evaluation, and assessment.

While Medicare essentially covers all acute services and on-going professional psychiatric services, it does not cover psycho-social rehabilitation programs. The emphasis of these services is to provide a supportive and structured environment for individuals with chronic mental illness. Participants may receive structured community support services, such as vocational training, life skills training, case management, assisted living services, etc., in addition to psychiatric evaluation and treatment. Psycho-social rehabilitation programs are primarily funded by Medicaid, state, and local funds. Beneficiaries are typically disabled as a result of their psychiatric illness. Table 1 summarizes Medicare's mental health benefits.

TABLE 1: Medicare Covered Mental Health Services

Benefit	Provider Type		Pharma-ceuticals	Beneficiary Sharing (Co-pay)	Service Limitations	Bad Debt Reimbursement to Provider
Inpatient	General hospital		Yes	Co-pay after 60 days	Spell of illness limits	Deduct. & Co-pays (BBA reduction to 55%)
	Distinct part psychiatric unit of a general hospital		Yes	Co-pay after 60 days	Spell of illness limits	Deduct. & Co-pays (BBA reduction to 55%)
	Specialty psychiatric hospital		Yes	Co-pay after 60 days	Spell of illness limits and 190 lifetime limit	Deduct. & Co-pays (BBA reduction to 55%)
	Professional services		Not Applicable	20% of fee schedule	None	None
Outpatient	Partial hospital-ization:	CMHC and hospital programs	No unless cannot be self-admin-istered.	20% of charges; although BBA will change gradually	None	Deduct. & Co-pays (BBA reduction to 55%)
	Professional: therapy (individual, group, family)		Not Applicable	20% + outpatient limi-tation: 62.5% (results in a 50%overall coinsurance)	None	None
	Professional: assessment and medical management		Not Applicable	20% (outpatient limitation does not apply)	None	None

Section 2: The Partial Hospitalization (PH) Program Benefit

1. Concept

The psychiatric hospital industry and the large managed mental health care organizations contacted for this report consider partial hospitalization to be within a medical model of psychiatric illness management. It is an organized modality that provides more structure and care coordination than independently provided professional and outpatient psychiatric services or social/community support services. It is considered a substitute for inpatient care, i.e., inpatient milieu without an overnight stay, or is frequently used as a step-down modality following an inpatient stay. The concept embraces the use of individual and group therapies, supplemented by medical management services. In this context, partial hospitalization has a short duration, which should act as a transition to a regular regimen of outpatient professional therapies, medication management, or community support services.

2. Legislative History and Intent

While hospitals could provide PH as an outpatient clinic service since the beginning of Medicare, it was not until OBRA 87 that the program was recognized as a concept distinct from outpatient services and the billing framework was established. OBRA 90 expanded the eligible providers of this service to include Community Mental Health Centers (CMHCs). Section 1835 (a) (2) (F) and section 1861(ff) of the Social Security Act used the medical illness model as the paradigm for the PH benefit. To be eligible for this service, an admission certification was required by a physician, a treatment plan had to be written, and medical necessity criteria had to be satisfied. Under section 1835 (a) (2) (F), PH was to be in lieu of inpatient services. Section 1861 (ff) also set out criteria requiring that the active treatment provided by PH covered services were "reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or

hospitalization." The 1861 (ff) statutory language led to variations in utilization by both the provider community and fiscal intermediaries. The PH benefit began to be used to provide less intense, long term care to individuals with chronic mental illness. The statutory language is discussed below in terms of its description of patient eligibility:

A. An acute service.

The language in 1861(ff), "With active treatment... to prevent ... hospitalization and to improve ... the individual's condition and ... functional level," indicates partial hospitalization services must be provided at the intensity necessary to avoid or prevent a patient from being hospitalized. Section 1835 (a)(2)(F) reinforced the notion by requiring payment determination to be based on a physician certifying, "the individual would require inpatient psychiatric care in the absence of such services." These two statutory requirements make clear that the patient's psychiatric symptoms are of such a serious nature that they place him/her at risk of needing more restrictive inpatient care without the active, intensive services of a partial hospitalization program. This interpretation is consistent with a medical practice model, which would be expected in a hospital PH program.

B. A less intense, long term care benefit.

However, the language in 1861(ff), "To prevent relapse ... or maintain the individual's condition and functional level," has been interpreted by some providers to mean a long term, chronic benefit. In this interpretation, the key words are **prevent relapse, maintain** and **functional** level. This interpretation is consistent with a psycho-social practice model, which would be expected in a community based program. However, this interpretation does not address the program intensity necessary to meet the statutory requirement for active treatment. When the benefit was expanded to include CMHC providers in OBRA 90, this interpretation was

recognized by the CMHC lobbying groups, which stated that their care models focused on a long-term maintenance approach.

However, the program intent as reflected in Sec. 1835 is an acute oriented service, which is a substitute for hospitalization. This view is affirmed by the cost estimates for the OBRA 90 provision.

3. Operational Definition

The statute does not define partial hospitalization programs per se, but rather describes a bundle of existing covered Medicare services that are structured within an organized integrated program. These services can be classified as two types: 1) **professional** services, which can be independently provided and billed, e.g., psychotherapies furnished by licensed practitioners; and 2) non-professional services furnished by a **facility**, e.g., activity therapies, and therapy services which cannot be independently billed (such as the services of personnel not eligible to bill independently, e.g., RNs, CSWs). Only the facility provided services, including the coordination aspects, are considered PH services under statute.

Normally, a facility provides a PH participant with individual and group therapies (not billable as professional services) for a full or half day, 3 to 5 days a week. These services are separately identified on the HCFA 1450 bill and subsequently reimbursed at cost. A prospective payment system is expected to replace cost reimbursement in the year 2000.

Medication management is generally delivered by physicians / psychiatrists and separately billed as a professional service using the Medicare fee schedule. Individual and group therapies can also be delivered by providers independently licensed to bill, except for licensed social workers, whose therapeutic services are

considered to be part of the facility charge (same rule applies to inpatient services). The BBA expanded separate professional billing to clinical nurse specialists, nurse practitioners, and physician assistants as long as their professional billing is not duplicated by the facility. Prior to this legislation, the services of these providers had to be included as a PH service and billed by the facility.

4. Contrast to Inpatient Services

Inpatient therapies and professional services provided by other than physicians, clinical psychologists, nurse specialists, and physician assistants, are included in the room and board rate and cannot be separately billed as professional services. Such therapies would include groups conducted by social workers (licensed or unlicensed), masters level psychologists, and psychiatric nurses. In PH, the same cost finding and professional billing approach are used. The PH facility rate covers the services of clinicians who cannot independently bill, such as unlicensed social workers, masters prepared clinicians, psychiatric nurses (other than clinical specialists and nurse practitioners), and other mental health workers.

Admission to a PH program is similar to an inpatient admission in that a certification is required by a physician and a treatment plan must be prepared. As in an inpatient program, the number of services that can be provided in PH is unlimited. However, the similarities to the inpatient service modality stop after the admissions process. Unlike the inpatient benefit, Medicare does not cover food (lunch) or medications (unless incapable of being self-administered) for PH patients. In addition, the outpatient mental health limitation of 62.5% is applied to professional services furnished within a PH program, except for assessment and medication management. With the application of this payment limitation, the patient co-pay portion of an outpatient professional service is 50%, versus the 20% for inpatient psychiatric and medical services.

Thus, PH is a hybrid of outpatient and inpatient services, which has elements of and close service substitutes of each. For example, under the statutory "substitute" definition, a PH eligible patient should also be eligible for an inpatient admission. As Medicare moves to a prospective payment system for hospital outpatient services, it will be more important to precisely define PH in order to distinguish it from other hospital outpatient psychiatric care.

5. The 1998 OIG Audit

In 1998, an OIG audit found that most of the PH units of service provided by a sample of CMHCs in FY 1997, 91%, were billed in error. Involved Fiscal Intermediaries (FIs) were asked to perform a medical review for a sample of claims from their CMHC providers. The OIG audit did not use a standardized medical review policy of PH, but rather relied upon the medical review policy adopted by each fiscal intermediary. Based on the medical necessity criteria employed by each FI, the OIG found that: 1) 79% of the units were not considered to be PH services, and 2) about 60% of the sampled beneficiaries did not meet the criteria to be eligible for PH services.[4] The balance of the claims billed in error lacked adequate documentation or were for services, which were considered unreasonable for a patient's condition. A subsequent audit of hospital outpatient psychiatric claims is expected to be released in the winter of 2000.

A subsequent informal review by the Program Integrity Group found that three service modalities appear to be delivered under the present PH rubric: 1) acute partial hospitalization, 2) less intensive outpatient programs, and 3) psycho-social

[4] Computed from data shown in the October 1998 OIG Report.

rehabilitation. Acute partial hospitalization emphasizes a medical model of care, in which PH is a substitute for or an immediate step-down modality from inpatient care. This definition is consistent with the statutory definition, which requires physician supervision. This definition is also consistent with the use of the benefit by other insurers and state Medicaid plans. An intensive outpatient program is not a substitute for inpatient care, but delivers an intensive level of structured outpatient psychiatric care and medical management. Some of the services delivered under this definition can also be accessed in hospital outpatient programs or as professional services. Psycho-social rehabilitation is a supportive program of services which combine mental health treatment in combination with other social community supports to maintain individuals with chronic mental illness in the community. Psycho-social programs have never been covered Medicare mental health services; consequently, psycho-social services generally are funded by public sector Medicaid programs, Substance Abuse and Mental Health Services Administration (SAMSHA) block grants, and state and local governments.

Section 3: Partial Hospital Utilization Measures and Payment Trends

1. Method of Analysis and Expectations

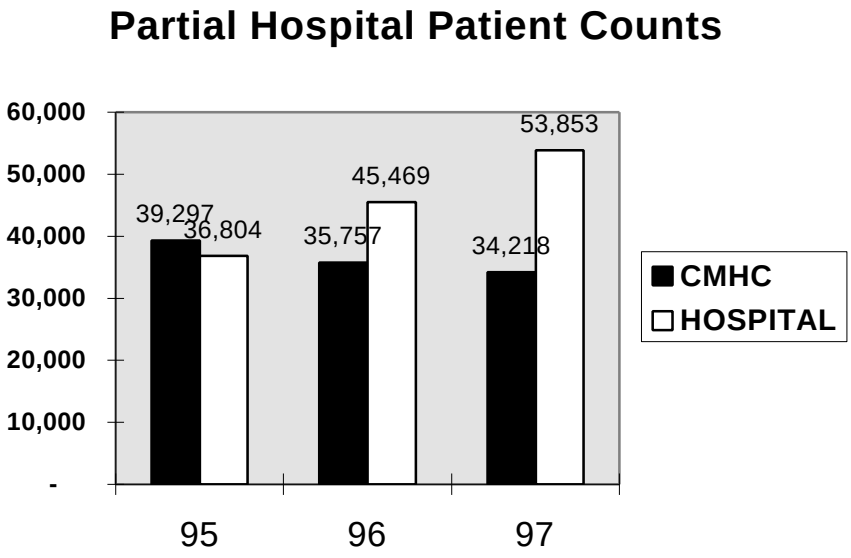
Three years of outpatient claims data from 1995 through 1997 were analyzed to determine the basic trends and utilization patterns for CMHC and hospital PH programs. The variables of policy interest are: a) the number of beneficiaries treated; b) patient age (aged versus disabled); c) the episode length; d) the frequency of service; e) psychiatric diagnoses; f) payments; and g) the percentage of dually eligible beneficiaries. This section analyzes these attributes over the three year period and compares CMHC to hospital PH programs. In order to analyze the length of PH episodes, a special 1996 cohort data set was created. In addition to 1996 claims utilization, the data set also included utilization data for the last six months in 1995 and for the first six months in 1997 so that care episodes that crossed calendar years would be properly counted.

2. Findings

A. Number of Beneficiaries Treated

About 88,000 beneficiaries were treated in PH programs in 1997, with CMHC programs treating about 40% of these. CMHC PH programs experienced a decline since 1995, while hospital PH programs experienced an increase.

The number of beneficiaries treated in PH programs increased from 76,000 in 1995 to 88,000 [5] in 1997, an annual rate of increase of about 7%. However, the increase had not been uniform, as CMHC PH programs experienced a modest decline, -9% in 1996 and -4% in 1997, while hospital PH programs experienced a large increase, 24% in 1996 and 18% in 1997.



B. Patient Age

60% of PH users were disabled (under 65), while 40% were elderly.

The ages of the beneficiaries treated in CMHCs were similar to those treated in hospital PH programs. About 60% of the Medicare patients in both program types were disabled, and the remaining 40% were elderly. In hospital PH programs, this ratio has been relatively constant since 1996, however, the percentage of elderly had increased in CMHC PH programs from 30% in 1994 to 40% in 1996.

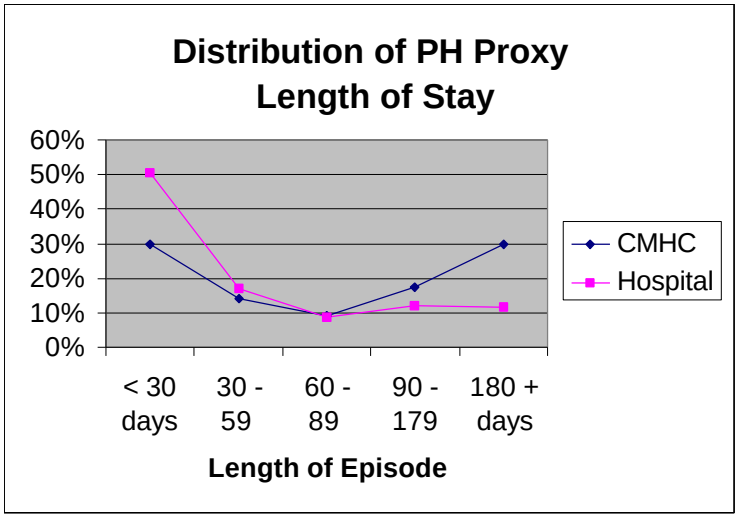
[5] This count may contain some duplicates. A Program Integrity Group analysis shows that the number of patients that cross-over from CMHC to hospital PH programs is less than 5%.

C. Episode Length

Hospital PH programs have shorter episode lengths. About 50% of the episodes of care in hospital PH programs had stays of 30 days or less, while less than 30% of the episodes in CMHC programs had stays of this duration.

Since PH is billed by the service type or by a billing period, no data are available on the true length of an episode, i.e., the number of days over which treatment is delivered. This information is relevant in characterizing the type of care, i.e., intensive, active treatment versus long term, and determining the episode frequency. A proxy episode length can be constructed by using billing interruption dates as a surrogate for the completion of a service. For example, if 30 days pass without a PH claim, it may be assumed that an episode has been completed. However, this proxy measure is dependent upon the period selected for billing interruption, as well as the billing practices of the provider. For example, using a 60 day interruption interval may result in fewer episodes than a 30 day interval.

A variety of episode breaks were tested to define an episode of service. A 45 day break was found to be the shortest episode break after which the distribution of stays did not change significantly. Using a 45 day billing interruption interval, Table 2



was developed. Based on this analysis, CMHC PH programs have longer episode lengths than hospital PH programs. About 50% of the episodes in hospital PH programs had stays of 30 days or less, while about 30% of the episodes in CMHC programs had stays of this duration. Longer stays suggest that less intensive care, most likely furnished to individuals with chronic mental illness (CMI), was being provided in CMHCs.

TABLE 2: Summary of Proxy Episode Length (1996)

Proxy Episode Length	CMHC PH Programs Episodes		Hospital PH Programs Episodes	
Less than 30 day	30%	44%	51%	68%
30 -59 days	14%		17%	
60 - 89 days	9%	56%	9%	32%
Greater than 90 days	47%		23%	
Total	100%	100%	100%	100%

D. Frequency of Service

87% of beneficiaries needing PH had 1 episode per year.

The majority of beneficiaries (87%), who used PH services in 1996, received one PH episode per year. Since the episode length can be quite long (almost 50% over 90

days for CMHC PH programs and almost 25% over 90 days for hospital PH programs), the service frequency must be interpreted in a somewhat different context than for an inpatient stay. Table 3 summarizes the 1996 frequency distribution of PH episodes for beneficiaries in CMHCs and hospitals, ignoring changes in diagnosis (which could be interpreted as the start of another episode). It appears that there is little difference in the frequency distribution between the CMHC and hospital PH programs.

TABLE 3: PH Episode Frequency Percentages (1996)

Number of Episodes / Year	CMHC PH Programs	Hospital PH Programs
1	**87.0%**	**86.8%**
2	**11.7**	**11.9**
3	**1.2**	**1.2**
4 and greater	**.1**	**.1**
TOTAL	**100.0%**	**100.0%**

E. Psychiatric Diagnoses

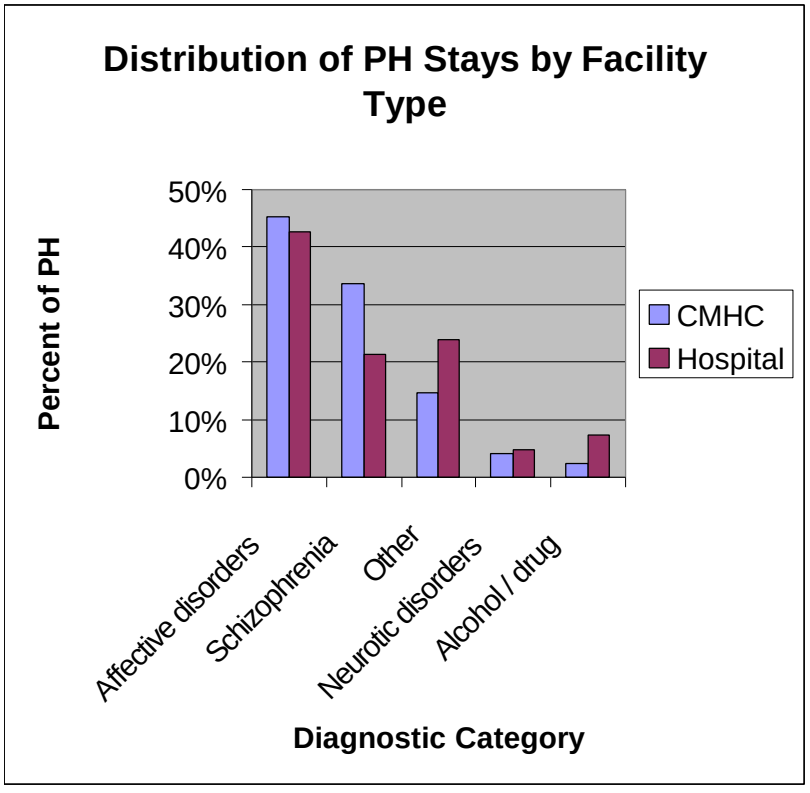
The predominant disease treated in PH programs is affective disorders, followed by schizophrenic disorders.

After reviewing the partial hospital claims data, the major psychiatric diagnostic categories shown in Table 4 were identified:

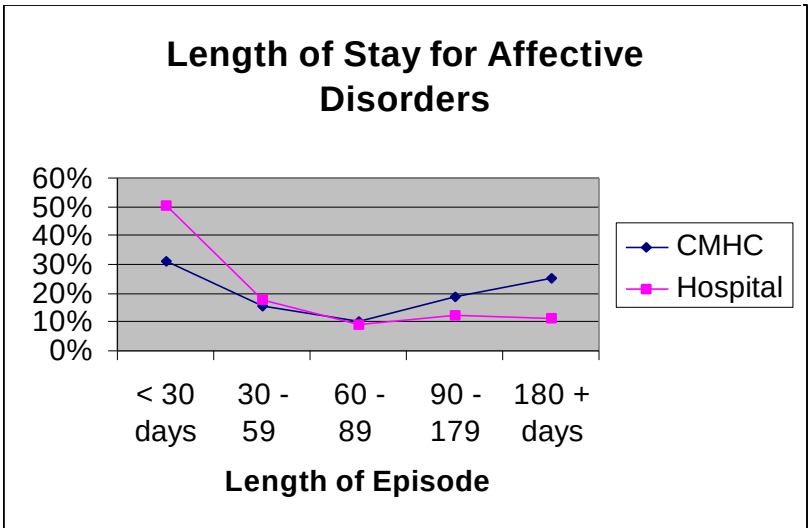
Table 4: Major Psychiatric Diagnostic Categories

Disorder	**ICD-9 Code Range**
Schizophrenic disorders	to 29599
Affective disorders	29600 to 29699
Neurotic disorders	30000 to 30099
Alcohol and drug dependence	30300 to 30499
All other	all other psychiatric codes

Differences in the incidence of the psychiatric disorders suggests that the Medicare beneficiaries treated in the CMHC PH programs may differ from those in the hospital PH programs. The predominant disease treated in partial hospital programs was affective disorders (about 45% of Medicare beneficiaries in CMHC PH programs; 42% in hospital PH programs), followed by schizophrenic disorders (about 35% of Medicare beneficiaries in CMHC PH programs; 21% in hospital PH programs). Drug and chemical dependency constituted the smallest



diagnosis category in the CMHC PH programs, 2%, but not in the hospital PH programs, where chemical dependency represented 7% of the PH beneficiaries. Longer CMHC episodes were also found for specific diagnoses, as illustrated for affective disorders.

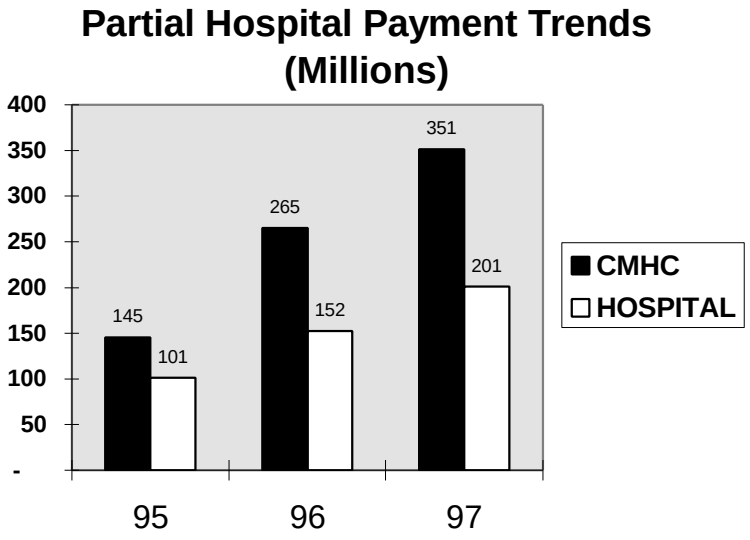


F. Payments

CMHC PH payments more than doubled to $350 million between 1995 and 1997. Hospital PH payments doubled in the same period to $200 million. The CMHC 1997 average cost per patient of $10,266, was more than twice the average hospital PH program cost, $3,755.

Total Payments

Hospital PH program costs were $100 million in 1995. Within two years, the payments had doubled to $200 million. The tremendous growth in program costs was also observed for the CMHC PH



programs. Their program costs more than doubled in the same time period, from $ 145 million in 1995 to $ 350 million in 1997. Tables 5a, 5b, and 5c, show total PH payments for 1995 through 1997, and compare CMHC to hospital PH program payments for the largest volume states. Changes by year are displayed on Tables 5d and 5e.

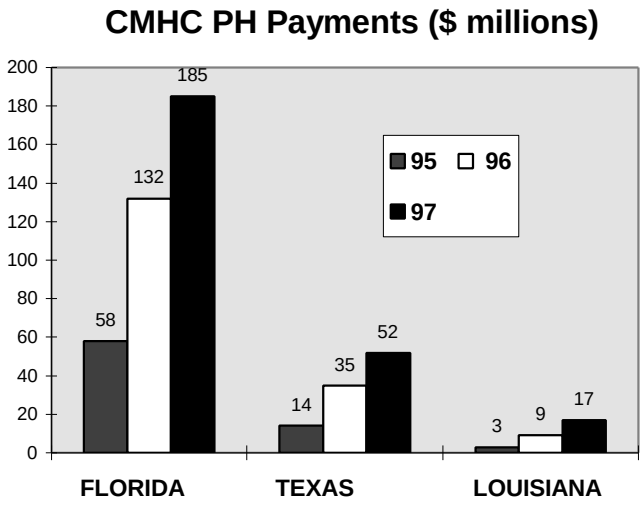
Cost per Patient (defined as provider payment per patient, excluding patient pay portions)

The CMHC 1997 average cost per patient of $10,266 was 175% higher than the average hospital PH program cost, $3,735. However, in 1995, the CMHC cost per patient was much closer to the hospital cost, $3,702 (CMHC) versus $2,746 (hospital), about 35% higher. This large differential in cost per patient is more evidence that the CMHCs, in particular, were not using an intensive, active treatment definition in the design of their PH programs.

Table 5-d shows the changes in hospital PH program payments and patient counts over the three year period. In 1997, hospital PH program payments grew slower than those in the CMHCs, increasing by about 100%. Half of this increase can be explained by the 46% increase in the number of patients treated: 54,000 in 1997 versus 37,000 in 1995. The 1997 cost per patient in hospital PH programs increased by 36% from $2,746 in 1995 to $3,735 in 1997 (16% increase per annum).

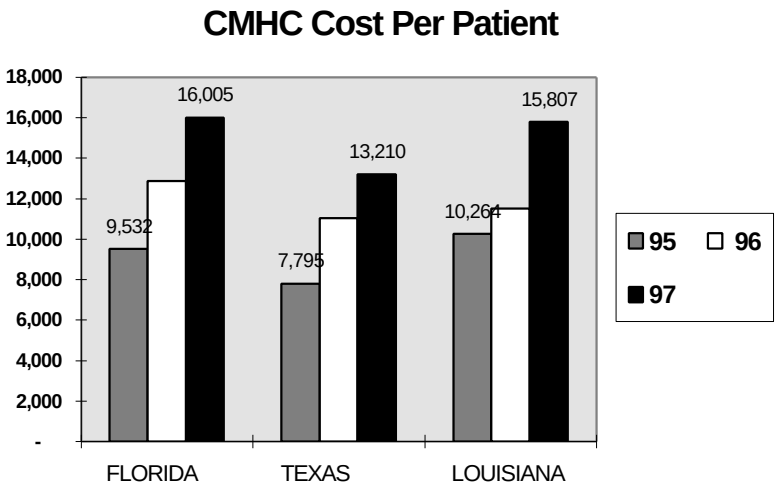
Table 5-e shows the change in CMHC PH payments and patient counts. In 1995, 39,000 Medicare patients participated in CMHC PH programs at a cost of $145 million. By 1997, program costs more than doubled to $351 million, while the number of beneficiaries treated diminished slightly to 34,000. The 1997 cost per patient in CMHC PH programs increased by 177% in the two year period, from $3,702 in 1995 to $10,266 in 1997 (66% increase per annum).

High Use States: Florida, Texas, and Louisiana



Florida, Texas, and Louisiana accounted for about half of the CMHC PH patients, but almost three-quarters of the cost. A similar disproportion was observed for the hospital PH programs, which accounted for about 20% of the PH patients, but one-third of the cost. Utilization and cost trends of these states are discussed below. Table 5-f compares the CMHC utilization and cost trends of these three states to those of other states.

Florida



In 1997, Florida CMHC PH programs had the largest number of patients, 11,600, and the highest level of payments, $185 million, which were more than half the total CMHC PH payments. In 1997, a

40% growth rate in CMHC payments was observed over the 1996 level, second only to the growth rate in Texas, 48%. The 1997 cost per patient in the Florida CMHC programs was the highest of any state, $16,005, and exceeded the national CMHC average cost by 55%.

Florida also had the largest hospital PH program payments in 1997, $45 million, which were about one-quarter of the entire hospital PH program cost. Their 1997 hospital cost per patient of $ 6,624 was the third highest, after Louisiana ($10,584) and Colorado ($8,398).

Texas

Texas had the second highest level of CMHC PH payments in 1997, $52 million, after increasing 48% over the 1996 levels, $35 million. With the number of patients increasing over the 1996 level by 23%, from 3,193 to 3,931, the cost per patient increased by roughly 20%. In 1997, the CMHC cost per PH patient in Texas was $13,210, the third highest cost (after Florida and Louisiana) and 25% above the national average.

Texas hospital PH program payments grew from $2.6 million in 1995 to $9.8 million in 1997. Some of this increased payment was explained by the 70% increase in the number of patients treated in the hospital PH programs; consequently, the cost per patient increased less than the payment growth, from $1,900 in 1995 to $4,100 in 1997. The Texas hospital PH program cost per patient was only 11% higher than the national hospital average, $3,700, while their CMHC costs per patient were almost 30% higher than the national CMHC average.

Louisiana

Louisiana experienced substantial growth of both CMHC and hospital PH programs over the 3 year period. In 1997, Louisiana had the third highest CMHC PH program payments ($17 million), followed by Alabama ($13 million), and Pennsylvania ($13 million). Louisiana also had the largest relative increase of CMHC payments of any state over the three year period, increasing by nearly 500% since 1995.

Louisiana hospital PH payments of $22 million were the third highest in 1997 after Florida ($45 million) and California ($37 million). Louisiana hospital payments grew by 400% from $5 million in 1995 to $22 million in 1997. Since the growth in patients treated was much lower, Louisiana had the highest cost per patient for hospital programs ($10,584 in 1997 versus the average cost of $3,735) and the second highest cost per patient for its CMHC PH programs ($15,807 in 1997 versus the average cost of 10,266).

G. The percentage of dual eligibles

A majority of beneficiaries using PH services, 58% on average, were also eligible for Medicaid (dual eligible).

In 1997, approximately 64% of beneficiaries using CMHC PH services and 54% of beneficiaries using hospital PH services were Medicaid eligible. Tables 5-a and 5-b show the percentage of dual eligibles (Medicaid buy-in %) treated in hospital PH programs in 1995 and 1996. Table 5-c shows the percentage of dual eligibles treated in both hospital and CMHC PH programs in 1997. In aggregate, 58% of all beneficiaries using PH services were dual eligibles in 1997. The states with the highest percentage of dual eligible beneficiaries

who used partial hospital services in 1997 are discussed below:

Hospital Programs: Of the 10 highest volume hospital PH programs, California had the highest percentage of dual eligibility, 77%, followed by Colorado, 63%, Massachusetts, 63%, Florida, 56%, and Louisiana, 56%. Texas had the second lowest Medicaid eligibility rate, 45%, and Georgia has the lowest rate, 44%.

CMHC Programs: Of the 10 highest volume states with CMHC PH programs, California also had the highest percentage of dual eligibles, 88%, followed by Kansas, 78%, Massachusetts, 77%, Florida, 69%, and Pennsylvania, 69%. As in hospital PH programs, Texas and Georgia also had the lowest percentage of the dual eligibles. Dual eligibility percentages may be affected by the proportions of the disabled in each state.

Largest Partial Hospitalization Volumes by
1995 Claims Data

FGT 10.6.99

		CMHC Programs			Hospital Programs			
	STATE	**Number of Patients**	**Payments (000s)**	**Payment Per Patient**	**Number of Patients**	**Payments (000s)**	**Payment Per Patient**	**Medicaid Buy-In % (By Person)**
1	FLORIDA	6,119	$ 58,329	$ 9,532	4,596	$ 14,121	$ 3,072	47%
2	TEXAS	1,757	13,695	7,795	1,388	2,589	1,865	47%
3	COLORADO	5,853	12,856	2,196	295	1,608	5,449	53%
4	CALIFORNIA	6,613	10,750	1,626	8,410	32,917	3,914	76%
5	PENNSYLVANIA	3,117	6,578	2,110	2,277	3,579	1,572	50%
6	ALABAMA	1,996	5,792	2,902	220	133	603	62%
7	KANSAS	1,581	4,650	2,941	38	99	2,605	61%
8	ARIZONA	588	3,671	6,243	636	1,115	1,753	72%
9	LOUISIANA	273	2,802	10,264	1,147	5,355	4,669	48%
10	ILLINOIS	639	2,632	4,119	2,405	8,927	3,712	49%
11	CONNECTICUT	207	1,119	5,405	2,441	6,362	2,606	41%
12	MASSACHUSSETS	617	1,656	2,684	1,849	5,862	3,170	44%
13	NEW YORK	304	1,069	3,518	2,168	3,871	1,786	51%
14	GEORGIA	48	243	5,060	1,049	1,646	1,569	53%
15	ALL OTHER	9,585	19,618	2,047	7,885	12,901	1,636	54%
	TOTAL	39,297	$ 145,460	3,702	36,804	$ 101,082	$ 2,746	55%

Largest Partial Hospitalization Volumes by 1996 Claims Data

FGT 10.6.99

	STATE	CMHCs			Hospitals				N
		Number of Patients	Payments (000s)	Payment Per Patient	Number of Patients	Payments (000s)	Payment Per Patient	Medicaid Buy-In % (By Person)	
1	FLORIDA	10,252	$ 132,191	$ 12,894	5,926	$ 33,659	$ 5,680	52%	
2	TEXAS	3,193	35,265	11,045	1,579	3,939	2,495	48%	
3	COLORADO	4,136	9,676	2,340	388	3,737	9,632	49%	
4	CALIFORNIA	1,563	7,674	4,910	8,223	32,169	3,912	75%	
5	PENNSYLVANIA	4,454	12,834	2,882	3,460	8,461	2,445	51%	
6	ALABAMA	2,354	13,199	5,607	657	455	693	31%	
7	KANSAS	667	1,702	2,551	87	96	1,103	62%	
8	ARIZONA	723	6,423	8,883	620	1,506	2,430	32%	
9	LOUISIANA	747	8,609	11,524	2,120	15,099	7,122	54%	
10	ILLINOIS	764	3,773	4,939	3,251	10,983	3,378	54%	
11	CONNECTICUT	222	1,036	4,669	2,994	8,346	2,788	58%	
12	MASSACHUSSETS	527	1,643	3,118	2,056	7,713	3,751	59%	
13	NEW YORK	471	1,354	2,876	1,819	3,279	1,803	45%	
14	GEORGIA	133	1,390	10,453	1,043	2,005	1,923	49%	
15	ALL OTHER	5,551	28,315	5,101	11,246	20,587	1,831	54%	
	TOTAL	35,757	$ 265,085	7,414	45,469	$ 152,035	$ 3,344	55%	

Largest Partial Hospitalization Volumes by State
1997 Claims Data

FGT 10.6.99

		CMHCs				Hospitals			
	STATE	**Number of Patients**	**Payments (000s)**	**Payment Per Patient**	**Medicaid Buy-In % (By Person)**	**Number of Patients**	**Payments (000s)**	**Payment Per Patient**	**Medicaid Buy-In % (By Person)**
1	FLORIDA	11,555	$ 184,941	$ 16,005	69%	6,926	$ 45,876	$ 6,624	56%
2	TEXAS	3,931	51,930	13,210	56%	2,364	9,809	4,149	45%
3	COLORADO	1,832	4,307	2,351	65%	361	3,032	8,398	63%
4	CALIFORNIA	1,256	12,404	9,876	88%	8,595	37,042	4,310	77%
5	PENNSYLVANIA	4,054	13,022	3,212	69%	3,764	8,510	2,261	47%
6	ALABAMA	2,354	13,199	5,607	59%	1,000	1,437	1,437	30%
7	KANSAS	348	1,041	2,993	78%	164	461	2,814	55%
8	ARIZONA	729	6,427	8,817	57%	693	3,861	5,572	47%
9	LOUISIANA	1,076	17,008	15,807	61%	2,082	22,036	10,584	56%
10	ILLINOIS	575	3,038	5,284	61%	4,128	13,531	3,278	52%
11	CONNECTICUT	222	1,036	4,669	63%	3,189	8,172	2,563	54%
12	MASSACHUSSETS	540	1,760	3,259	77%	1,987	7,594	3,822	63%
13	NEW YORK	471	1,354	2,876	47%	3,283	2,735	833	49%
14	GEORGIA	316	3,511	11,110	52%	1,111	3,076	2,769	44%
15	ALL OTHER	4,959	36,288	7,318	58%	14,206	33,974	2,392	54%
	TOTAL	34,218	$ 351,269	10,266	64%	53,853	$ 201,147	$ 3,735	54%

Largest Partial Hospitalization Volumes by Sta

FGT 10.6.99

Hospital Programs TA

	Number of Patients			Payments (000s)			Cost per	
	95	96	97	95	96	97	95	
1 FLORIDA	4,596	5,926	6,926	14,121	33,659	45,876	3,072	5
2 TEXAS	1,388	1,579	2,364	2,589	3,939	9,809	1,865	2
3 COLORADO	295	388	361	1,608	3,737	3,032	5,449	9
4 CALIFORNIA	8,410	8,223	8,595	32,917	32,169	37,042	3,914	3
5 PENNSYLVANIA	2,277	3,460	3,764	3,579	8,461	8,510	1,572	2
6 ALABAMA	220	657	1,000	133	455	1,437	603	
7 KANSAS	38	87	164	99	96	461	2,605	1
8 ARIZONA	636	620	693	1,115	1,506	3,861	1,753	2
9 LOUISIANA	1,147	2,120	2,082	5,355	15,099	22,036	4,669	1
10 ILLINOIS	2,405	3,251	4,128	8,927	10,983	13,531	3,712	3
11 CONNECTICUT	2,441	2,994	3,189	6,362	8,346	8,172	2,606	2
12 MASSACHUSSETS	1,849	2,056	1,987	5,862	7,713	7,594	3,170	3
13 NEW YORK	2,168	1,819	3,283	3,871	3,279	2,735	1,786	1
14 GEORGIA	1,049	1,043	1,111	1,646	2,005	3,076	1,569	1
15 ALL OTHER	7,885	11,246	14,206	12,901	20,587	33,974	1,636	1
TOTAL	36,804	45,469	53,853	101,082	152,035	201,147	2,746	3

Percentage Change over prior year

1 FLORIDA	29%	17%	138%	36%	
2 TEXAS	14%	50%	52%	149%	
3 COLORADO	32%	-7%	132%	-19%	
4 CALIFORNIA	-2%	5%	-2%	15%	
5 PENNSYLVANIA	52%	9%	136%	1%	
6 ALABAMA	199%	52%	243%	216%	
7 KANSAS	129%	89%	-3%	381%	
8 ARIZONA	-3%	12%	35%	156%	
9 LOUISIANA	85%	-2%	182%	46%	
10 ILLINOIS	35%	27%	23%	23%	
11 CONNECTICUT	23%	7%	31%	-2%	
12 MASSACHUSSETS	11%	-3%	32%	-2%	
13 NEW YORK	-16%	80%	-15%	-17%	
14 GEORGIA	-1%	7%	22%	53%	
15 ALL OTHER	43%	26%	60%	65%	
TOTAL	24%	18%	50%	32%	

Largest Partial Hospitalization Volumes by Stat

FGT 10.6.99 **CMHC Programs** **TAI**

	Number of Patients			Payments (000s)			Cost per	
	95	96	97	95	96	97	95	
1 FLORIDA	6,119	10,252	11,555	58,329	132,191	184,941	9,532	12,
2 TEXAS	1,757	3,193	3,931	13,695	35,265	51,930	7,795	11,
3 COLORADO	5,853	4,136	1,832	12,856	9,676	4,307	2,196	2,
4 CALIFORNIA	6,613	1,563	1,256	10,750	7,674	12,404	1,626	4,
5 PENNSYLVANIA	3,117	4,454	4,054	6,578	12,834	13,022	2,110	2,
6 ALABAMA	1,996	2,354	2,354	5,792	13,199	13,199	2,902	5,
7 KANSAS	1,581	667	348	4,650	1,702	1,041	2,941	2,
8 ARIZONA	588	723	729	3,671	6,423	6,427	6,243	8,
9 LOUISIANA	273	747	1,076	2,802	8,609	17,008	10,264	11,
10 ILLINOIS	639	764	575	2,632	3,773	3,038	4,119	4,
11 CONNECTICUT	207	222	222	1,119	1,036	1,036	5,405	4,
12 MASSACHUSSETS	617	527	540	1,656	1,643	1,760	2,684	3,
13 NEW YORK	304	471	471	1,069	1,354	1,354	3,518	2,
14 GEORGIA	48	133	316	243	1,390	3,511	5,060	10,
15 ALL OTHER	9,585	5,551	4,959	19,618	28,315	36,288	2,047	5,
TOTAL	39,297	35,757	34,218	145,460	265,085	351,269	3,702	7,

Percentage Change over prior year

1 FLORIDA		68%	13%		127%	40%	
2 TEXAS		82%	23%		157%	47%	
3 COLORADO		-29%	-56%		-25%	-55%	
4 CALIFORNIA		-76%	-20%		-29%	62%	2
5 PENNSYLVANIA		43%	-9%		95%	1%	
6 ALABAMA		18%	0%		128%	0%	
7 KANSAS		-58%	-48%		-63%	-39%	-
8 ARIZONA		23%	1%		75%	0%	
9 LOUISIANA		174%	44%		207%	98%	
10 ILLINOIS		20%	-25%		43%	-19%	
11 CONNECTICUT		7%	0%		-7%	0%	-
12 MASSACHUSSETS		-15%	2%		-1%	7%	
13 NEW YORK		55%	0%		27%	0%	-
14 GEORGIA		177%	138%		472%	153%	1
15 ALL OTHER		-42%	-11%		44%	28%	1
TOTAL		-9%	-4%		82%	33%	1

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Impact of the Three Highest Use States on CMHC Partial Hospitalization Program Trends

TAB

STATE	Number of Patients			Payments (000s)			Cost per P	
	95	96	97	95	96	97	95	9
FLORIDA	6,119	10,252	11,555	58,329	132,191	184,941	9,532	12,89
TEXAS	1,757	3,193	3,931	13,695	35,265	51,930	7,795	11,04
LOUISIANA	273	747	1,076	2,802	8,609	17,008	10,264	11,52
All Other States	31,148	21,565	17,656	70,633	89,021	97,390	2,268	4,12
TOTAL	39,297	35,757	34,218	145,460	265,085	351,269	3,702	7,41
Change over prior year								
FLORIDA		4,133	1,303		73,862	52,750		3,36
TEXAS		1,436	738		21,570	16,665		3,25
LOUISIANA		474	329		5,806	8,399		1,26
All Other States		(9,583)	(3,909)		18,387	8,369		1,86
TOTAL		(3,540)	(1,539)		119,625	86,183		3,71
Percentage Change over prior year								
FLORIDA		68%	13%		127%	40%		35
TEXAS		82%	23%		157%	47%		42
LOUISIANA		174%	44%		207%	98%		12
All Other States		-31%	-18%		26%	9%		82
TOTAL		-9%	-4%		82%	33%		100

Section 4: Non-Medicare Use of Partial Hospitalization

In order to gauge the usage of PH outside of Medicare, a limited number of other purchasers of mental health services, e.g., private insurers, large employers, managed behavioral health care organizations, and state Medicaid programs were contacted. In addition, the Veterans Administration was also contacted. A survey was administered to each respondent and documents showing the medical necessity criteria for PH were obtained. This information showed that an acute service definition is typical of the definition used in the industry outside of Medicare.

While these structured interviews were limited in number, a significant proportion of the lives covered under managed behavioral health care firms were represented by the contacted firms because of the high industry concentration. The interview was conducted at the highest level of the organization that had knowledge about PH. Since this was a non-randomized survey, the results are not generalizable to the entire industry. However, consistent results illustrate that the environment for this service is quite different from that currently experienced by Medicare. The results of the interviews and the documented medical necessity criteria are discussed below:

1. Interview Information

The interview guide shown in **Appendix 2** was developed to help determine the use and payment for PH by private insurers, large employers, managed behavioral health care organizations, and state Medicaid programs. The following sections briefly summarize the results from the interviews and are followed by a summary of the medical necessity criteria that were obtained from some of the contacted organizations.

A. Definition:

PH is used as an acute modality of very limited duration. One respondent described the intensity as being similar to an inpatient service, with the additional criteria that a patient had suitable and stable support structures. Another respondent stated that of the state's 400,000 Medicaid recipients, only a handful would be expected to be admitted to a PH at any given time. Psycho-social rehabilitation services are considered a separate modality from partial hospitalization. Medicaid programs typically cover psycho-social services under the rehabilitation benefit option as "Structured Day Treatment Services," which typically follow a rehabilitative care model.

B. Efficacy of the PH Modality:

The behavioral managed care firms believe that partial hospitalization programs reduce the need for inpatient hospitalization. With a much lower per diem cost, the use of the PH modality appears to be very cost effective when properly managed. Behavioral managed care firms typically negotiate an all-inclusive daily fee that frequently includes professional service components.

C. Cost Containment Approaches:

Two general cost containment approaches are used: utilization management and limiting the benefit. All but one respondent relied upon an aggressive utilization management approach. Each approach is discussed below:

1. Management

Behavioral managed care firms and two state Medicaid plans reported that the benefit was managed. The admission, treatment plan, the duration of service, and the discharge must be approved using criteria developed by the plan. After initial approval, a case would be concurrently reviewed as the next level of care was being coordinated. Typically, approval of continued care was being reviewed as frequently as every 3 - 7 days. Unlike Medicare, physicians do not have to certify admissions, as this process is part of the utilization management function.

2. Limiting the benefit

One insurer stated that its outpatient mental health visits were limited to 25 per year (standard option, any combination of professional or PH services), which could easily be exhausted within 1 week of a PH stay. Essentially, the benefit and high co-pays were so restricted that there was no need to worry about defining and controlling it. One managed care firm stated that it prefers to manage against dollar limits rather than against utilization measures; ostensibly, due to the problem in defining standardized utilization counts, and because it provides greater flexibility in designing a service package.

D. Fraud and Abuse Issues with PH

None of the survey respondents reported fraud and abuse issues as experienced by Medicare. The primary reasons cited for this favorable experience were aggressive behavioral managed care techniques and / or

limitations on the benefit.

E. PH in the Veterans Administration

Because of the unique character of this delivery system, the VA is separately discussed in this report. The VA partial hospitalization programs serve adult and geriatric patients suffering from acute episodes of chronic psychiatric conditions typically including one or more of schizophrenia, bipolar/manic depression, and/or post traumatic stress syndrome. PH is almost exclusively used as an inpatient step down modality; consequently, it is not considered a substitute for inpatient care. PH admissions are generally authorized by psychiatrists, although it is often arranged by care managers.

PH is now considered a short stay program of under 3 weeks (15 treatment days) or less duration. The reduction in stays has been a recent phenomenon as it often exceeded 30 days as recently as six years ago. The reduction in stays reflects the contemporary organizational culture within the VA, which currently advocates community based as opposed to hospital centered treatment and improved medication and therapy interventions. In addition, there are significant financial disincentives associated with recommending inpatient or the use of PH. As a result, it is only used when necessary and step down is encouraged. Patient status is reviewed daily, and as soon as the condition is stabilized, a transfer to a less intense treatment environment is recommended.

2. Summary of Medical Necessity Criteria (MNC)

As part of the information gathering process, the medical necessity criteria documents from 8 interview respondents were reviewed. Since insurers typically

relied upon the clinical protocols of contracted providers, only the criteria of the managed care organizations and the two state Medicaid plans were included in this summary. Using these source documents, an analysis was made of the definitions and attributes of PH as well as the clinical standards that are used. The following summarizes this information:

A. Definitions and Attributes of PH

1. PH is an alternative to inpatient care, either as a step-down from inpatient or as an alternative to an inpatient admission.

2. PH is for the treatment of acute psychiatric conditions, which would include an acute exacerbation of a chronic condition, but not the treatment of a chronic condition per se.

3. PH programs should be operational a minimum of 5 days per week and the program should be a minimum of four hours per day. Patients would not necessarily have to attend all five days, but this level of intensity should be available for those who need it.

4. While there is general agreement that PH should be a relatively short-term intervention for acute episodes of illness, there are no guidelines as to what is "short term." Length of stay is driven entirely by medical necessity criteria. This is entirely appropriate but it means that clear medical necessity criteria and clinical case review are essential.

B. Standards

Standards fall into five general categories: Facility Accreditation, Required Services, Program Intensity, Admission or Continuing Care Criteria (Medical Necessity Criteria), and Exclusionary Criteria. These standards are summarized in Table 7 and are discussed below:

Facility Accreditation - Several behavioral managed care firms required external accreditation (JCAHO).

Required Services - Minimum requirements were found for PHs in terms of staffing, program structure, program content (required therapeutic services), quality improvement policies and procedures, treatment planning, and discharge planning etc., but did not include the criteria for admission.

Intensity Standards - Minimum hours or patient participation per day and/or minimum days of operation per week.

Admission or Continuing Care Criteria (Medical Necessity Criteria (MNC)): These are the clinical criteria used to determine the appropriate level or intensity of care. The basic medical necessity criterion for an acute inpatient admission is that the patient is an imminent danger to self or others. The managed care organizations (MCOs) generally define medical necessity criteria for PH in similar terms, the difference being a function of: (1) patient stability, and (2) the degree to which the patient is an imminent (or immediate) risk. If the patient is stable enough to be medically unsupervised for brief periods of time (at home with family overnight or alone at home for a few hours at a time) the patient can be managed in a PH setting. If not, an acute inpatient setting is required. The primary differences are summarized

in the Table 6.

TABLE 6: Summary of Medical Necessity Criteria

INPATIENT CANDIDATE	PH CANDIDATE
Imminent danger to self or others	Not imminently dangerous
Patient's condition is unpredictable in the short-term (significant decompensation can occur in less than 24 hours)	Patient is unlikely to decompensate in less than 24 hours or home supervision is sufficient to insure that patient will be returned to hospital safely should decompensation occur or patient can be relied upon to call for help

Once a patient is admitted, the Medical Necessity Criteria for continuing care are generally the same as the criteria required for admission. One example of the additional requirements is that appropriate treatment interventions are being implemented and "...progress is clearly evident and can be described in objective terms..."

Exclusionary Criteria - Common exclusionary criteria that would rule out an admission for acute care settings include autism, mental retardation, organic brain syndrome, etc.

TABLE 7: Summary of PH Clinical Standards by Interviewed Organization

(Letters refer to each organization interviewed)

	Behavioral Managed Care				State Medicaid			Federal
	A (1)	B	C	D	E (1)	F	G	H
FACILITY ACCREDITATION								
Accredited by JCAHO or CHAMPUS	_		_					_
REQUIRED SERVICES								
Individual, group and family therapy	_		_			_		
Daily psychotherapy	_							
Vocational Planning	_		_		_			
Medication Management	_	_	**Daily**		_	_		
Nursing	_	_	_		_			
Education and Activity therapies	_		_		_	_		
Multi-disciplinary team	_	_	_		_			
INTENSITY STANDARDS								
Minimum days of operation per week	**5**		**7**		**7**			**5**
Minimum hours per day	**4**	**4**	**4**				**3**	**3**
Equal to inpatient hospital except for hours/day	_	_	_		_			
Staffing Ratio							**1/6**	
MEDICAL NECESSITY CRITERIA								
DSM IV Diagnosis	_	_			_	_		
Alternative to IP care (danger to self or others).	_	_		_	_	_	_	
Likely to respond to therapeutic intervention)	_	_			_			
Acute, not chronic conditions (but can include an acute exacerbation of a chronic condition)	_	_	_	_	_	_	_	_

	Managed Care				State Medicaid			Federal
	A (1)	B	C	D	E (1)	F	G	H
EXCLUSIONARY CRITERIA								
Patient has a medical condition that would interfere with program participation.	_			_				
Primary problem is social (housing, family conflict) or medical	_	**I**						
Autism	_			_				
Mental Retardation	_			_				
Delirium, dementia	_			_				
Mental Disorder due to General Medical Cond.	_			_				
Primary Substance Abuse	_			_				

I - Implicit
Note: (1) There was overlap in criteria between one of the Medicaid programs and a behavioral MCO.

C. Contrast between Medicaid programs and MCOs.

The three state Medicaid agencies were concerned primarily with licensing and certification of programs and facilities.[6] As a result, they tended to focus on the Program and Intensity standards, since these are most relevant to licensing and the certification process. The MCOs were concerned primarily with controlling utilization; consequently, they view the Medical Necessity Criteria as their paramount concern. However, many MCOs also lay out program and intensity standards as well. Both MCOs and state Medicaid plans tend to have intensity standards.

[6] Two Medicaid plans were interviewed, and the third state had previously shared this information.

When Program Standards are explicitly stated, they tend to define PH as a treatment modality that provides the same level of staffing and services as an acute inpatient program, the major difference being that PH programs offer 4 to 8 hours of care per day while the inpatient facilities offer 24 hour care.

D. Discussion of the standards

From the standpoint of controlling utilization of PH services, both program standards and medical necessity criteria are important. Program standards would limit which facilities could bill for PH services. Medical necessity criteria would define payment eligibility in terms of the patient's clinical condition. That is, payment for PH services would be made only if a patient met the medical necessity criteria for PH. Obviously, this would require a mechanism for reviewing medical necessity criteria.

Program Standards alone, without the simultaneous use of medical necessity criteria, would probably have a limited impact on utilization. If program standards were defined so as to require PH programs to offer staffing and program content similar to inpatient units, programs that currently fail to meet such standards would have two choices - go out of business, or enhance their staffing and services. The first option would decrease utilization, the latter would probably result in unchanged utilization, but higher rates.

Section 5: Conclusion

About 88,000 beneficiaries were treated in PH programs in 1997, with CMHC programs treating about 40% of these. A majority, 60%, of Medicare beneficiaries using PH services are disabled (under 65), and 40% are elderly. Between 1995 and 1997, CMHC PH programs experienced a 13% decline in patients treated, while hospital PH programs experienced a 45% increase.

CMHC PH payments more than doubled from $145 million in 1995 to $350 million in 1997. Of this $205 million increase, almost 90% was due to the three highest payment growth states: Florida, Texas, and Louisiana. The large increase in payments and the declining number of patients served resulted in a substantial increase in the CMHC average cost per patient: $10,266 in 1997 versus $3,702 in 1995. The 1997 CMHC average costs were highest in the three states with the highest payment growth rates: Florida, $16,005 per patient; Texas, $13,210 per patient; and Louisiana, $15,807 per patient.

While hospital PH program payments also increased substantially between 1995 and 1997, from $100 million to $200 million, about half the increase was explained by the increased number of patients treated. Consequently, the average cost per patient in hospital PH programs increased modestly from $2,746 in 1995 to $3,735 in 1997. In the three states with the highest CMHC payment growth (Florida, Texas, Louisiana), the average costs of hospital PH programs were much lower than CMHC PH programs, although their hospital average cost exceeded the national average.

Partial hospitalization is considered to be an acute care service by the non-Medicare purchasers of mental health services surveyed for this report. A significant portion of care provided under Medicare's PH benefit does not appear to be a substitute for acute hospital care as evidenced by the large proportion of episodes exceeding 90 days. Part of the explanation for this appears to be due to the confusion created by the statutory language that describes the benefit and the varying interpretations of what constitutes partial hospitalization. Actions taken under the Administrator's 10 point plan should help maintain PH as intensive, active treatment. Strategies to accomplish this

goal include:

- Using standardized definitions and protocols in the medical review of providers.
- Intensifying reviews.
- Defining more stringent criteria for delivering the service.

Consistent with these practices, HCFA has issued a Program Instruction for Fiscal Intermediaries, which is included in Appendix 1.

Appendix 1

PROGRAM MEMORANDUM
INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-99-39 **Date SEPTEMBER 1999**

SUBJECT: Payment Safeguard Review Instructions for Psychiatric Partial Hospitalization Claims

Background

In 1998, a five-State review conducted by the Office of the Inspector General (OIG), determined that over 90 percent of 1997 Community Mental Health Center (CMHC) partial hospitalization program (PHP) claims in those States did not meet Medicare coverage requirements. There were two primary problem areas. The first was that a significant number of beneficiaries had no documented diagnosis of mental illness or had a documented diagnosis that would prevent them from benefiting from a PHP. The second problem was that many programs did not offer the intensity of services required by the statute that defines partial hospitalization services.

In September 1998, HCFA announced a 10-point CMHC initiative to correct the identified problems. The plan details a comprehensive strategy to improve HCFA's management of the CMHC benefit. This program memorandum is one component in the CMHC initiative and describes an intensified medical review of CMHC PHP claims.

Intensified Medical Review

Beginning October 1, 1999, take steps to start intensified medical review of CMHC PHP claims. The purpose of this increased review is twofold. First, it is necessary to conduct an audit level sufficient for HCFA to make a determination of the types of billing errors which are occurring in order to target our future medical review resources in reducing the payment error rate. Secondly, the audit will assist HCFA in identifying providers with systemic problems related to egregious billing practices.

Contractors processing claims in the five states identified in the October 5, 1998 OIG audit (Florida, Texas, Colorado, Pennsylvania, and Alabama) are to begin reviewing a minimum of 30 percent of claims for each CMHC provider in these states for 90 days. If contractors in these states are already doing higher levels of review, this instruction allows continuance of these higher levels. Providers in the five-State review of partial hospitalization claims have been identified as posing significant risk to the integrity of the Medicare program. All other contractors, apart from those in the designated States, should focus their efforts on aberrant providers as determined by data analysis of claims and conduct focused medical reviews as instructed in the Medicare Intermediary Manual (MIM) §3939. The intensified approach is necessary to mitigate the risk in this emergency situation posed by the 90 percent payment error rate. Medicare CMHCs have received notification through their Regional Administrators of this increased review activity (copy attached). Claims for CMHC PHP will be reviewed for both beneficiary eligibility requirements and medically reasonable and necessary requirements.

Discontinuation of Increased Medical Review

Thirty percent CMHC PHP claims medical review will continue for each CMHC provider in the five identified States for a minimum of 90 days. After the initial 90 days, discontinue the increased review when the CMHC has achieved a payment denial rate of 10 percent or less. For other providers the level of review should continue as follows: For the next 90-day period providers with a 10 percent to 30 percent denial rate should continue at a 30 percent level of review, 30 percent to 50 percent denial rate should be increased to 50 percent, providers with a greater than 50 percent payment denial rate should be placed on 100 percent claims review. Continue this level of review for another 90-day period then recheck the denial rate. Repeat this process through the end of 2000. Once the increased level of medical review has been initiated for a provider, select your review sample from all claims with dates of service during the specified 90-day review period regardless of the date the claim was submitted.

You should continue using the medical review instructions in this program memorandum for all future medical review until further notice.

Hospital Outpatient Partial Hospitalization Medical Review

The level of medical review of hospital out-patient PHP claims should also be increased based on data analysis which identifies potentially aberrant billing/utilization patterns.

Provider Education

Contractors should make available educational efforts such as newsletters, bulletins, or contractor educational seminars or outreach to facilitate provider compliance with the partial hospitalization benefit and billing requirements.

Reporting Requirements

To determine the effectiveness of this new review strategy, we will develop a reporting format and a program memorandum of instruction which will be sent to you at a later date.

Medical Review Instructions

A. General--Effective immediately the following medical review instructions will be in place for all fiscal intermediaries (FIs) for all types of review for partial hospitalization claims. HCFA's policy is based on the following citations:

The Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

The Social Security Act, §§1861(ff) and 1832(a) define the partial hospitalization benefit and provide for coverage of partial hospitalization in a hospital or CMHC setting.

The Social Security Act, §1861(s)(2)(B) references partial hospitalization in a hospital setting.

The Social Security Act, §1835(a)(2)(F) references physician certification and plan of care.

The Social Security Act, §1833(e) requires services to be documented in order for payment to be made.

42 CFR 410.43, 410.110, and 424.24(e) set forth the conditions and exclusions for the partial hospitalization benefit.

HCFA Ruling 97-1 clarifies Limitation on Liability rules for appeals.

B. Bill Review Requirements--FIs must conduct review of partial hospitalization bills in accordance with applicable MIM sections. For partial hospitalization services provided by CMHCs, see MIM §3651 (medical review guidelines in §3920.1K3), §3604 (except §3651.C); MIM §3920.1K3 (documentation criteria for outpatient hospital psychiatric services in §3112.7C of the MIM manual). FI standard operating procedure for soliciting additional documentation, claim adjudication, and recoupment of overpayment. The following components should be used to help determine whether the services provided were accurate and appropriate.

1. Initial Psychiatric Evaluation/Certification--Upon admission, and periodically thereafter, a certification by the physician must be made that the patient admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization

services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

2. Treatment Plan--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

3. Progress Notes--§1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan.

C. Bill Review Process

For all selected claims, review medical documentation and determine whether the services provided were covered. The reviewer should apply the criteria in the following order (e.g., benefit category requirements, statutory exclusion from coverage, then reasonable and necessary) when making a payment determination. In order to be covered, a service must meet all three of the following criteria:

1. Make a Benefit Category Determination--Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a partial hospitalization program must be under the care of a physician who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.

Patients meeting benefit category requirements for Medicare coverage of a partial hospitalization program comprise two groups: Those patients who are discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a partial hospitalization program. Recertification must address the continuing serious nature of the patient's psychiatric condition requiring active treatment in a partial hospitalization program.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations which ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

2. Determine Services are not Statutorily Excluded from Coverage--Determine whether the services are excluded from coverage under any provision in §1862(a) of the Act. Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

a. Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors).

b. Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual.

c. Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients.

d. Drugs and biologicals that cannot be self administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29).

e. Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals.

f. Family counseling services for which the primary purpose is the treatment of the patient's condition.

g. Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition.

h. Medically necessary diagnostic services.

Partial hospitalization services which make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a partial hospitalization program. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services provided in a partial hospitalization program. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

3. Determine Services Provided are Reasonable and Necessary--This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individuals condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention expected to maintain or improve the individuals condition and prevent relapse may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a partial hospitalization program do not require 24-hour daily supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the partial hospitalization program. Patients admitted to a partial hospitalization program generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multi-disciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in partial hospitalization programs may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour daily supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

D. Reasons for Denial

1. Examples of benefit category §1861(ff) or §1835(a)(2)(F) denials for partial hospitalization services generally include:

- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;

- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for individuals with chronic mental illness; and

- Patients who are otherwise psychiatrically stable or require medication management only.

Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

2. The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Social Security Act:

- Services to hospital inpatients;

- Meals, self-administered medications, transportation; and

- Vocational training.

Coverage denials made under §1861(ff) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

3. The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a partial hospitalization program;

- Treatment of chronic conditions without acute exacerbation of symptoms which place the individual at risk of relapse or hospitalization; and

- Services to a skilled nursing facility resident that should be expected to be

provided by the nursing facility staff.

Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply.

The implementation date for this program memorandum is October 1, 1999.

Any necessary workload readjustment should be negotiated with the regional office.

These instructions should be implemented within your current operating budget.

This program memorandum may be discarded after October 1, 2000.

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Appendix 2:

Partial Hospitalization
Interview Questions for Other Payers
February 1999

Payer Background

1. Type of insurer:

   a. Private
      --Product lines _____Private_____Public

   b. Government (specify)

2. Estimated number of program participants in mental health coverage (000's) _____

   a. Estimated proportion at "risk" _____ "non-risk"_____

3. Use of a mental health carve out yes no

   a. Proportion of program participants in carve-out_____

4. Use of care management
   a. For all services yes no NA
   b. All mental health yes no
   c. For substance abuse yes no NA

5. Across product lines could you give a range of the mental health benefit limits, e.g., visits, days, dollars (disregard graduated changes in co-pays):
   a. Inpatient
   b. Therapies (e.g., individual, group)
   c. Partial hospitalization
   d. Other

Service Definition, Clinical Indications and Authorization

NOTE: If your program does not use the terminology "partial hospitalization," we would be interested in discussing whether you have coverage for something similar. For purposes of Medicare, psychiatric partial hospitalization programs are meant to provide intensive psychiatric care of an acute nature, providing active treatment utilizing clinically recognized therapeutic interventions. These programs are expected to closely resemble a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Under Medicare, a partial hospitalization program can

include the following services:

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law)
- Occupational therapy requiring the skills of a qualified occupational therapist
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;
- Drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered);
- Individualized activity therapies that are not primarily recreational or diversionary;
- Family counseling (the primary purpose of which is treatment of the individual's condition);
- Patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); and
- Diagnostic services.

1. How is partial hospitalization defined clinically in terms of:

    a. Types of therapies (group/individual)
    b. Professional services (physician/CP)
    c. Program tracts (CD/geriatric/adolescent/chronic/etc.)
    d. Are written clinical definitions available (please attach).

2. What clinical indications justify admission to a partial program? (If there are guidelines that could be shared that would be helpful.)

    a. Step-down from an inpatient unit
    b. Admission diversion
    c. Crisis stabilization
    d. Dysfunction as a result of acute psychiatric symptoms
    e. Availability of support system for patient supervision when not at program.
    f. What, if any, evidence do you require to show that a less intensive level of treatment has been tried and has failed?

3. Who can authorize this service?

    a. Care manager
    b. Attending physician/psychiatrist
    c. Other

4. How long is it authorized for, and what is the rationale for the interval?

    a. Open ended
    b. Intervals of days.
    c. Recertification needed every_____days.

5. Does authorization for partial hospitalization include authorization for the physician services? Do you require certain levels of physician supervision?

6. What clinical indications justify discharge from a partial program?

    a. Step-up to an inpatient unit
    b. Outpatient step-down
    c. Abatement of acute symptoms or patient stabilized
    d. To what levels of care are patients discharged, and approximately in what proportions?

Utilization

7. What utilization trends have been experienced over the past few years concerning (be specific with data if possible):

    a. Inpatient stays (LOS) and admissions
    b. Outpatient therapies
    c. Partial hospitalization LOS and admissions

8. Have you experienced over utilization by partial hospitalization programs? If so, how has that been controlled? Have any fraud and abuse investigations been targeted at partial programs?

9. Has partial hospitalization been found to be effective in reducing inpatient hospitalization stays and/or admissions? For which types of patients (such as diagnostic groups, adolescent, geriatric, etc.)

10. Is partial hospitalization considered to be a substitute for inpatient care, or to be a lower level of care or lower level of supervision?

Payment

11. How is payment defined?

    a. A bundled approach, that includes all service components (professional and facility)?
        1. Negotiated
        2. Non-negotiated fee schedule

        a-1. If bundled, what unit of service is used? (day, half-day, number of groups or therapies, per case etc.)

    b. A fee for service approach, where each component is paid separately.
        1. Negotiated
        2. Non-negotiated fee schedule

    c. Other (specify)?

    d. Have you made any recent changes? What prompted those changes?

12. What trends have been observed in partial hospital rates?

13. What is the general level of client cost-sharing?

Providers

14. For purposes of the benefit package do you distinguish partial hospitalization from:
    - psychosocial rehab
    - intensive outpatient
    - substance abuse day treatment or
    - other types of psychiatric day treatment programs?
    - adult day care

15. What types of provider settings do you use for partial hospitalization services, e.g., hospitals, CMHCs, others, e.g., freestanding facilities? What proportion of your client population is seen in each of the settings?

Client Population

16. What are the characteristics of the overall mental health client population you serve (e.g., proportion that are acute, versus chronic), and how does the "partial hospitalization service" fit into the range of services you provided?

17. What are the most common diagnoses and characteristics of the client population relative to the 5 axes in DSM-IV? Do you use specific GAF score (i.e., Score of general adaptive functioning) criteria as a guideline for admission and continued stay? If so what typical score do you apply?

18. Do you apply criteria that require:

    a. Capacity for **improvement** in the client's illness or level of functioning in order to cover partial hospitalization treatment?

    b. On the other hand, would you provide coverage for purposes of **maintaining** a client with a chronic condition, if there is no acute symptomatology, but without the partial hospitalization services the **client is likely to require inpatient care**?

    c. Would you provide coverage for purposes of **maintaining** a client's level of functioning and prevent decompensation, **but the client is not at risk of needing inpatient care**.

Purchaser Interests

19. How interested are various purchasers in terms of providing partial hospitalization benefits. e.g., public versus private purchasers, employers of various sizes?